RESEARCH PAPER

A Cautionary Tale of Downloading Public Health in Ontario: What Does It Say about the Need for National Standards for More Than Doctors and Hospitals?

Mise en garde contre le délestage de la santé publique en Ontario : avons-nous besoin de normes nationales pour autre chose que les médecins et les hôpitaux?

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Abstract

The 2003 SARS outbreak highlighted the importance of maintaining an adequate public health (PH) infrastructure, and cast doubt on the wisdom of basing the system locally without adequate provisions for higher-level oversight and coordination. Structurally, it highlighted the policy legacy of the 1998 Ontario decision to download full responsibility for funding PH services to municipal governments, forcing such

services into budgetary competition with the "hard" services traditionally provided by local government. The federal role in PH has traditionally been minimal; PH was never included as a mandatory service in the *Canada Health Act*, while reform proposals have focused upon such admittedly important directions as pharmacare and home care rather than PH. Although PH has moved up the policy agenda, with a focus on pandemic preparedness, the Ontario events suggest a pressing need for setting national and provincial/territorial standards for PH, and developing mechanisms for enforcing them.

Résumé

L'épidémie de SRAS de 2003 a mis en relief l'importance de maintenir une infrastructure de santé publique (SP) adéquate et a remis en doute le bien-fondé d'un système axé sur des ressources locales, sans prendre des dispositions appropriées pour assurer une supervision et une coordination par des paliers de gouvernement supérieurs. Du point de vue structural, l'épidémie a mis en évidence les répercussions de la décision de 1998 du gouvernement de l'Ontario de confier l'entière responsabilité du financement des services de santé publique aux administrations municipales, forçant ces services à faire concurrence, pour les fonds budgétaires, aux services « de base » fournis habituellement par les administrations municipales. Le rôle fédéral dans la SP a traditionnellement été minime; la SP n'a jamais été incluse dans la *Loi canadienne sur la santé* comme étant un service obligatoire, et les propositions de réforme portaient principalement sur des priorités reconnues telles que l'assurance-médicaments et les soins à domicile, au lieu de la SP. Bien que celle-ci ait gravi quelques échelons dans les priorités stratégiques, en raison de l'accent placé sur la préparation à une pandémie, les événements survenus en Ontario témoignent d'un besoin pressant de normes provinciales et territoriales en matière de SP et de mécanismes pour les appliquer.

The SARS outbreak, tainted water, "mad cow" disease and West Nile virus, plus threats of pandemic influenza, have momentarily refocused public attention on the importance of public health (PH). This window of opportunity suggests that time may be ripe for rethinking its jurisdictional underpinnings. This paper presents a cautionary tale of Ontario's downloading of PH to municipalities as an illustration of the potential implications of current arrangements, which make it difficult to achieve and maintain national standards.

Although healthcare is constitutionally under provincial jurisdiction, provinces must comply with the national conditions set out in the *Canada Health Act* if they wish to receive federal transfer payments. No such requirements apply to non-physician services outside hospitals, including PH and environmental protection, mental

health, most non-physician ambulatory care, dental care, home care and outpatient pharmaceuticals. Recent comprehensive reviews of healthcare evoked pressures to expand national conditions to encompass acute home care and catastrophic pharmaceutical costs (National Forum on Health 1997; Romanow 2002; Canada, Standing Senate Committee on Social Affairs, Science and Technology 2002), but they too left PH largely absent from the debate.

Policy Communities

Political scientists use the term "policy community" to define "that part of a political system that has acquired a dominant voice in determining government decisions in a field of public policy … by virtue of its functional responsibilities, its vested interests and its specialized knowledge" (Pross 1992). Policy communities include government agencies, pressure groups, media and individuals that have an interest in a particular policy field, and can be loosely divided into the "subgovernment," who influence policy in that area, and the "attentive public," who merely follow the debate (Coleman and Skogstad 1990). Although they may disagree about policy details, members of a policy community tend to share a worldview and a vocabulary. The downloading example highlighted that medicine, PH and local government form different, if potentially overlapping, policy communities. In this case, players in the public health policy community included the Ministry of Health, Public Health Branch; Association of Local Public Health Agencies (AlPHa); Ontario Medical Association (OMA); Ontario Public Health Association (OPHA); local boards of health and some interested individuals. The municipal-related policy community included the Ministry of Municipal Affairs and Housing, Municipal Policy Branch; Association of Municipalities of Ontario (AMO); and individual municipal governments.

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Public Health

There are a number of different ways of describing what PH is. Many, but not all, of its activities deal with the health of populations rather than individuals. Much, but

not all, of the focus is on prevention. Some, but not all, of the activities are carried out by organizations designated as PH agencies. These activities include, but are not restricted to, the "health protection and promotion" functions, defined as encompassing the following activities: "disease surveillance, disease and injury prevention, health protection, health emergency preparedness and response, health promotion and relevant research undertakings" (Canada, Standing Senate Committee on Social Affairs, Science and Technology 2003).

The *Constitution Act, 1982* gives provincial governments exclusive power to make laws in relation to matters regarding municipal institutions; they can alter municipal roles and responsibilities, subject only to the constraints of public opinion. Although PH falls under provincial/territorial jurisdiction, provincial governments can delegate these responsibilities. Naylor estimated that primary responsibility for PH services in Canada rests with "about 140 health units and departments that serve populations ranging from 600 to 2.4 million people, with catchment areas from 4 to 800,000 square kilometres" (Health Canada 2003). In most provinces and territories, many functions have devolved to regional health authorities, with often vague provisions for reporting and accountability. Critical mass is frequently lacking. The federal government retains a limited ability to legislate PH "through its powers over, variously, the criminal law, matters of national concern for the maintenance of 'peace, order and good government,' quarantine provisions and national borders, and trade and commerce of an interprovincial or international nature" (Health Canada 2003), all falling, for the most part, outside the boundaries of what is traditionally viewed as health policy.

The Case of Ontario

Ontario is the only Canadian province requiring municipal governments to share PH costs. Historically, the network of local boards of health had responsibility for PH activities, with the provincial government gradually assuming a greater role in providing a share of the financing, as well as in mandating a set of "core programs" that all local boards were required to deliver (Powell 2006; Ontario Ministry of Health, Public Health Branch 1997). Ontario's PH system thus evolved from a fragmented system to one with 42 PH units (since reduced to 36), and a provincial infrastructure to support PH at the local level and ensure the delivery of mandatory programs and services as defined under the *Health Protection and Promotion Act* (Government of Ontario 1990) and its regulations. In practice, guidelines for mandatory programs were determined by consultation between an established "public health" policy community, consisting of the public health division within the Ministry of Health working closely with staff of the local boards of health. Ontario paid 75% of approved costs for all units outside Toronto, and 40% for the six Toronto units. Certain programs that local government was historically reluctant to fund – particularly sexual health,

AIDS education and tobacco control – received 100% provincial funding. On January 1, 1998, however, the province downloaded full responsibility for funding of PH services to municipal governments. The history of how and why this occurred despite warnings from PH experts clarifies the limitations of consensual models of decision-making, and suggests the need for some mechanisms to strengthen the ability of the PH policy community to ensure that minimum standards are maintained, even over periods where visible crises do not propel PH onto the policy agenda.

The "Who Does What" Exercise

Whenever there are multiple levels of government, there is a possibility for confusion, waste and mismanagement. The newly elected Progressive Conservatives under Premier Mike Harris saw the streamlining of Ontario's government as one of their key mandates. They began in May 1996 by commissioning what was called the "Who Does What" Advisory Panel, chaired by former Toronto mayor and federal Mulroney government cabinet minister David Crombie, to advise the Minister of Municipal Affairs and Housing on "ways to eliminate duplication, overregulation and blurred responsibility for the delivery of local and provincial services" (Ontario Ministry of Municipal Affairs and Housing 1996). The advisory panel's mandate included advice on taxation and assessment, and disentangling provincial–municipal responsibilities and governance without changing the costs assumed by each level. However, many observers believed that the province wished to gain full control over funding of education (to enable the government to meet an election promise) while getting out of the business of direct service delivery and reducing net expenses to allow for a balanced budget and a promised 30% tax cut.

One underlying distinction made in the Crombie review was between "hard" services to property (e.g., road maintenance, sewers) and "soft" services to people (e.g., social assistance, education, PH programs and services). This distinction rests in part on the understanding that people are more mobile than property. Low-income areas have both the highest needs for "soft" services and the least ability to pay for them; indeed, jurisdictions may have an incentive to provide poor-quality services to low-income people to induce them to move elsewhere. Analysts thus argue that services to people should be financed at the highest possible level of government. In contrast, a "closer to home" philosophy would allow each locality to set its own standards and service levels. Balancing flexibility and universality is always difficult. In the case of infectious disease, it must also be recognized that a service failure in one jurisdiction can lead to an epidemic elsewhere; PH is only as strong as its weakest link.

The advisory panel recommended that "the Province fully fund all boards of health to deliver mandatory programs" (Crombie 1996); its recommendations were supported by PH and municipal government representatives.

The Provincial Response

Following the "Who Does What" logic would have resulted in a net shift of costs for soft services to the provincial level. To ensure "balance," the advisory panel proposed shifting many hard services costs to local governments, including full capital costs for transit. In the long run, this funding model was unlikely to be sustainable, particularly since municipal governments must rely upon a property tax base and are prohibited from running deficits. Thus, local governments have less flexibility than do other levels of government to take on debt in order to finance infrastructure, and are thus likely to underinvest.

The provincial government was dissatisfied with the panel's recommendations. In early 1997, Bill 152, the "Services Improvement Act," was introduced, purportedly to implement the "Who Does What" recommendations (Government of Ontario 1997). This bill called for "downloading" all responsibility for funding PH, long-term care, ambulance services, social housing and a greater proportion of social assistance to the municipal level of government, and increased local responsibility for paying for public transit and road maintenance. In return, the province would assume full responsibility for education. Under this proposed legislation, the province would assume responsibility for a program whose expected costs would decrease over time as the population of school-aged children decreased, while downloading a number of counter-cyclical and increasing-cost programs to municipal governments. Janet Ecker, Minister of Community and Social Services (1996–1999), stated that "the province will continue its responsibilities for standards" for public health activities, but not for funding them (Ontario Ministry of Community and Social Services 1997).

The next stage was for Minister Ecker to set up a "Who Does What" Provincial/Municipal Transition Team to "advise the government on the design, implementation and management of proposed new roles and responsibilities for provincial and municipal governments" (Ontario Ministry of Municipal Affairs and Housing 1997). PH was not at the table; the co-chairs were the parliamentary assistant to the Minister of Municipal Affairs and Housing and the president of the Association of Municipalities of Ontario (AMO), a coordinating body heavily oriented towards the interests of the smaller communities. Other members included politicians and staff from both provincial and municipal governments. AMO was particularly worried about the unpredictable costs associated with such programs as social assistance and housing. According to comments by those involved in the process, PH received almost no attention; in financial terms, it represented a relatively small and relatively predictable expense, particularly compared to such volatile programs as social housing and social assistance.

AMO's counter-proposal accepted municipal responsibility for funding such services as ambulance and PH, while proposing that the province assume greater responsibility for long-term care and social assistance. After negotiation, a revised agreement was announced.

The "Who Does What" policy exercise had the consequence of moving responsibility for public health from the PH policy community (who strongly opposed downloading these services) into the wider "municipal government policy community," allowing the debate about policy options to focus primarily on the fiscal framework (specifically, how to make the trade-offs "revenue neutral" or achieve specified fiscal targets), with little attention given to the impact of proposed changes on PH. Final decisions around policy direction were concentrated within the Premier's Office and cabinet (to whom Crombie reported). Once that occurred, lobbying efforts by the PH community to reverse the decision and maintain a stronger provincial role proved to be futile: PH remained invisible.

A related process led to the downsizing of the provincial Ministry of the Environment and a shift of responsibility for water testing to municipal governments. As had been the case for PH, the provincial government did not see any need for technical support at the provincial level, assuming that private sector testing laboratories could provide whatever support might be required. Neither did they maintain the former reporting structures; with PH not at the environment table, the need to ensure that water advisories were copied to local health departments also "slipped through the cracks" (O'Connor 2002). The provincial expertise in developing PH testing was also eliminated, including such projects as developing tests for West Nile virus.

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Consequences

It is difficult for one level of government to control spending decisions at other levels. Municipal governments were soon pressing Ontario to give them "greater flexibility" in the sorts of PH programs that they were forced to provide. In response, in March 1999, Ontario reversed itself and agreed to pay half of PH costs, with the potential of playing an even greater role for "a few programs with provincewide dimensions such as Healthy Babies, Healthy Children and vaccines," but also gave local governments "the ability to tailor programs to meet local needs," which could be interpreted as a code phrase for allowing standards to slip (AMO 1999). The province also handed over "full title, including assets and liabilities, of water and sewer facilities previously held

by the Ontario Clean Water Agency" to municipal governments (O'Connor 2002).

Another short-term consequence was a drop in the level of health expenditures by the provincial government; the provincial association of health units estimated that the province's PH units were spending considerably less than the amount needed to maintain their "core programs." Again, the invisibility of PH ensured that this did not become an issue until after the 2003 SARS outbreak, at which time the *Globe and Mail* noted that provincial transfers to PH units had dropped to $201 million for the fiscal year 2002–2003, as opposed to $254 million in the 1999–2000 fiscal year (Mackie and Campbell 2003). Neither had the provincial government retained the capacity to support or properly investigate outbreaks of communicable disease. Indeed, this decentralization of responsibility left unclear the extent to which local governments had chosen to increase their own funding to fill the gap.

Although the PH policy community believed that strong provincial standards are essential to maintain the PH system, they often found it difficult to make their case to local decision-makers. Although the province retained the power of the Ministry of Health to monitor and enforce the delivery of mandatory programs and services at the local level, releasing new mandatory guidelines in December 1997 that set minimum standards and requirements for the provision of public health services, municipalities expected "pay for say" and were strongly opposed to what they saw as rigid and prescriptive standards. Even though the province has "absolute power when it chooses to utilize it" (White 1991), it had to decide how much it was willing to antagonize municipal governments.

More recently, the combination of SARS and fears of bio-terrorism has caused more attention to be paid to infectious disease prevention. However, many PH units had insufficient resources to deliver even the existing mandatory programs; efforts to describe "core programs" thus face a tension between levelling up or levelling down (Provincial Auditor of Ontario 2003). Post-downloading, many Ontario programs that served at-risk families began to vanish. Even communicable disease control for such diseases as tuberculosis was seen as lower priority. As the provincial Auditor General noted, even required programs were not being performed in many health units; "2002 per capita funding for mandatory health programs and services, while averaging $37 for the province, ranged from approximately $23 per capita to $64 per capita among the 37 local health units" (Provincial Auditor of Ontario 2003). In short, PH remained below the radar screen – until the epidemics began.

It is striking that, in their exemplary efforts to control SARS, the PH departments of the units serving Toronto had to resort to begging and borrowing resources from universities, hospitals and other jurisdictions, and reallocating staff from other pressing activities (Basrur et al. 2004). Thus, even in the midst of their ultimately successful management, the SARS crisis casts doubt on the wisdom of basing the system purely within local government (D'Cunha 2004). This worry was reinforced by the expert

panels scrutinizing PH in the wake of SARS (Canadian Medical Association Journal 2003; Expert Panel on SARS and Infectious Disease Control 2003, 2004; Health Canada 2003). As the Campbell Commission investigating SARS in Ontario noted:

> The Commission has heard continuing reports of municipalities diverting public health staff and funds to other departments, boards of health with members whose sole objective was to reduce health budgets, and medical officers of health fighting municipal bureaucracies and budget constraints to attain a proper standard of public health protection. Not all local health units are dysfunctional. Some are well governed, but certainly the current weak state of affairs is unacceptable and cannot continue. …
>
> Ontario cannot go back and forth like a squirrel on a road, vacillating between the desire for some measure of local control and the need for uniformly high standards of infectious disease protection throughout the entire province. A clear decision point is required before some deadly infectious disease rolls over the province. (Campbell 2005)

Among the Commission's recommendations were ensuring provisions for regular monitoring, and making program standards legally enforceable.

In response to Naylor (Health Canada 2003) and similar reports, the federal government has set up the Public Health Agency of Canada, with a broad mandate encompassing prevention of chronic disease and injuries, as well as responding to PH emergencies and infectious disease outbreaks. Its approach, however, followed the recommendations of the national SARS task force and adopts the model of voluntary cooperation and "capacity-building partnerships." This voluntary approach explicitly rejects the idea that the federal government should mandate programs or standards, arguing that any approach that "sought to conscript P/T personnel or unilaterally regulate their activities would lead to unfunded mandates and F/P/T political and legal confrontations" (Health Canada 2003). Similarly, the federal government appears reluctant to coerce provincial and territorial governments to meet international commitments (Wilson et al. 2006), choosing instead to adopt a voluntary consensual model (Wilson 2001; Wilson et al. 2004). History suggests that this approach is likely to work well as long as consensus exists and the risks of failure to act are obvious. These conditions appear to be influencing such encouraging developments as the new Public Health Agency of Canada, the establishment of PH agencies in several provinces (including Quebec, British Columbia and Ontario) and a number of projects at both national and provincial/territorial levels examining capacity needs. It seems unwise, however, to base a system on the assumption that this will always be the case.

Obvious failures often create their own corrections, and at the time this paper was being written, the lack of monitoring highlighted by the Campbell Commission was

being addressed in Ontario under new, dynamic leadership (Basrur 2005; Office of the Auditor General of Ontario 2005). However, reviews of PH capacity in other provinces that had decentralized PH into regional health authorities reveal a similarly disquieting de-emphasis on PH (Sutcliffe et al. 1997) and an absence of information about even what PH activities were actually being conducted within regional authorities.

The relative political weakness of prevention as opposed to more clinically focused services is a widely recognized phenomenon. Even before SARS, fears that public health capacity would be adversely affected by its difficulty in competing with acute care were echoed in a number of reports and papers urging that greater attention be paid to the PH infrastructure (Canadian Medical Association Journal 2002; Federal/Provincial/Territorial Advisory Committee on Population Health 2001; Naus and Scheifele 2003; Schabas 2002; Sullivan 2002). After SARS, a series of reports and papers echoed these concerns (Basrur et al. 2004; Basrur 2005; Campbell 2004, 2005; D'Cunha 2004; Expert Panel on SARS and Infectious Disease Control 2003, 2004; Health Canada 2003). A number of provinces have been investigating capacity needs, and arguing for clearer standards on at least the provincial level (Agency Implementation Task Force 2006; Association of Local Public Health Agencies 2005; Basrur et al. 2004; Basrur 2005; BC Ministry of Health 2005; Capacity Review Committee 2006; Government of Newfoundland and Labrador 2006a,b; Government of Ontario 2004, 2006; Moloughney 2005; Office of the Auditor General of Ontario 2005; Pietrusiak 2003; Provincial Auditor of Ontario 2003; Provincial Task Force on the Prevention and Control of Communicable Diseases in Health Institutions and Ambulance Services 2004; Public Health Research and Knowledge Translation Network 2005; Rush 2005).

Discussion

PH activities tend to be among the most cost-effective components of healthcare systems (World Health Organization 2002). Much of the activities of PH also qualify as "public goods." One inherent characteristic of public goods is that their benefits cannot be restricted to those who choose to pay for them. Clean air, where it exists, is available to everyone and everything that breathes. Because rational individuals acting solely to maximize their economic self-interest have an incentive to refuse to pay for such goods, but to reap whatever benefits others are willing to provide, this "free rider" problem has the paradoxical result of leading to the underacquisition of public goods, where "underacquisition" is defined in economic terms as the quantity for which such rational decision-makers would have been willing to pay if free-riding did not exist. These characteristics thus provide a justification, on both practical and moral grounds, for government to compel the provision and financing of public goods (Olson 1965). PH can also create externalities; failure of one jurisdiction to act can place others at risk. Indeed, as Wilson has stressed, the risk of pandemics has increased the pressure

on national governments to comply with international standards, a policy direction that is inconsistent with allowing federal systems to permit different standards to be set at the provincial/territorial (or local) level (Wilson 2004, 2005; Wilson and Lazar 2005; Wilson et al. 2004, 2006).

In the aftermath of the Romanow and Kirby reports, arguments have been made that the federal government should expand the scope of services publicly financed under medicare, ensure that wait time standards are met, or deal with issues in paying for pharmaceuticals. Although this logic is indeed justifiable, this focus on clinical services seems inadequate.

PH was never included in the *Canada Health Act* or its precursors, which focused on paying for the most expensive components of healthcare delivery – first hospital care, and then physician services. The debate about the *Canada Health Act* retained this narrow focus (Bégin 2002; Lewis et al. 2001; Canada, Standing Senate Committee on Social Affairs, Science and Technology 2001), and appears to have assumed that provinces and territories would continue to fund and deliver basic PH programs and services merely because they recognized their importance, and hence would not require national conditions. The downloading of PH in Ontario and the province's subsequent experiences with tainted water, West Nile virus and SARS (in addition to similar outbreaks in other provinces, including a waterborne outbreak of cryptosporidiosis in North Battleford, Saskatchewan) suggest that the assumption that policy makers will be guided solely by evidence of effectiveness may be unrealistic. In the final analysis, in the absence of a structure that guarantees the ability to set and enforce national (and even international) standards, it is highly plausible that once the current awareness passes, jurisdictions will again neglect longer-term PH in favour of shorter-term imperatives, to the grave detriment of the health of Canadians – and, perhaps, the world.

In the final analysis, disease will appear at the local level, and local providers must be prepared to recognize and deal with it. Without support and information, many may find it difficult to cope. Just as it is recognized that the ability to maintain an adequate minimum level of services for medical services across Canada is in large part dependent upon the ability of senior levels of government to provide (or withhold) funding, we suggest that the ability to enforce adequate PH standards may also require both targeted funding (Chambers 1997) and clear enforcement mechanisms. While these should be evidence-based and derived after careful consultation, the logic of prevention implies that it is shortsighted to place these efforts entirely at the mercy of local (or provincial/territorial) economic and political conditions, particularly since the consequences of inaction may be borne far more widely.

As provincial report after provincial report concludes, PH capacity has been allowed to deteriorate across Canada. We recognize that the question of national standards evokes the classical federalism debates about uniformity versus flexibility. However, the *Canada Health Act* reflects what was then a national consensus that

certain services – reasonable access to medically necessary services within hospitals or by physicians – should be available to any Canadian, regardless of region or province of residence. A similar consensus exists that all Canadians should have access to primary and secondary education. In contrast, there is a consensus that other services can appropriately be allowed to vary across jurisdictions. Accordingly, there will need to be a debate about which PH services should be universal, which determined within provinces/territories and which left to local option.

The case for national standards is clearest for services that involve externalities (particularly communicable disease), but also for services affecting equitable access to high-quality, cost-effective care (including health promotion and disease prevention). There will also need to be a debate about how to pay for such programs, and the best mechanisms to enforce (and update) standards once they are agreed. We do not attempt to preclude this debate and enforce our own judgments. Neither do we delude ourselves that it will be easy. We do suggest that it is necessary, and even overdue.

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